EXHIBIT 1
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HB 738

INFORMATIONAL TESTIMONY ON HB 738
Before the House Business and Labor Committee
Jerry Keck, Administrator
Employment Relations Division
Department of Labor and Industry
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Mr. Vice-Chairman, members of the committee, for your record my name is Jerry Keck. I am the administrator of the Employment Relations Division in the Department of Labor and Industry. It is my pleasure to appear before you as an informational witness on HB 738. The Department has assisted Rep. Mendenhall in the drafting of this bill and I appreciate the opportunity to appear first to explain what the bill would do.

The Employment Relations Division is charged with much of the regulatory responsibility in the workers' compensation system. Ever since I have been the administrator at ERD, I have heard anecdotal assertions from employers that Montana had very high workers' compensation premiums; but I heard from injured workers' representatives that our benefits are very low. The question always is, how can that be? Are our premiums high? Are our benefits low? After spending a significant amount of time and study looking into those questions, I can answer both of them YES. The Oregon premium study indicates that we are the 5th highest state in our workers' compensation premiums. We have reexamined that study and confirm we believe it to be relatively accurate. We have also examined our statutory benefits and confirm that our statutory benefits are pretty low.

Over a year ago, the Governor asked Lt. Gov. Bohlinger to head up a study of the workers' compensation system. The department provided staff to conduct the study. Part of that study was to commission the Workers' Compensation Research Institute to do their standard administrative inventory of Montana's workers' compensation system. Those of you who attended the Workers' Compensation Educational Conference heard Duncan Ballantyne report the results of the WCRI study. It confirms that we have high premium rates and that we have relatively low statutory benefits. BUT, because of specific factors in Montana in what is happening in our system, we pay very high dollars per $100 of payroll in actual workers' compensation benefits.

Those factors include: 1) we have a significantly higher frequency rate of injuries; 2) we have people off work too long, and 3) our medical costs are too high. So, we know that in order to reduce our costs (and thus our premiums), we have to do significantly better in addressing safety in the workplace to reduce the number of injuries. We need to be creative in finding ways to get injured workers back to work much more quickly. And we need to find ways to reduce our medical costs in the workers' compensation system. We are currently spending 65% of our benefit dollars on medical costs for injured workers; only 35% of our benefit dollars go for lost wages or indemnity benefits.

The Commissioner of Labor has now established the Labor-Management Advisory Council on Workers' Compensation. It is made up of 5 representatives of management (employers) and 5 representatives of labor (injured workers). The Council will review all of the factual information that we have gathered about Montana and how we compare to our regional states. The will make recommendations on how we can make changes to our system to reduce costs and premiums without reducing benefits to injured workers. The Advisory Committee will be looking at all of these issues over the interim and making recommendations to the 2009 session. Part of this process was holding the Workers' Compensation Educational Conference so that Council members, all of the stakeholders in the workers' compensation system and all of you could gain a better understanding of the issues in workers' compensation.

In this context, I appreciate that Rep. Mendenhall wanted to bring forward proposals this session that would begin to address the cost drivers in the workers' compensation system. I am hopeful that we will be able to have a good open discussion and reach agreement on the ideas put forth in HB 738 to begin to address our high costs. What I have said to the representatives of injured workers is that we have to find ways to begin reducing premiums before we can realistically consider increasing our relatively low statutory wage replacement benefits. I firmly believe that we can reduce costs and reduce premiums without cutting the benefits to injured workers. Because the causes of our high costs are frequency of claims, duration of time away from work and medical costs – it is not our wage loss benefits.

This bill doesn't address frequency or safety; it doesn't address duration or return to work. Those are major areas that the Advisory Council will be taking on. This bill does begin to address our high medical costs. I will try to explain what the bill does and then the proponents and opponents will help to clarify the issues.

WHAT DOES THE BILL DO?

Section 1 provides a statutory provision defining when a claim can be closed. This is important to consider in understanding the pieces that contribute to high premiums. Insurers build a certain amount of reserves into their calculations of future liability for any open claim. Currently, every case in Montana remains open indefinitely unless the claim is fully and finally settled. We have a fairly low rate of claims that are fully and finally settled. So we have a very high number of open claims. Our statute provides that if medical benefits have not been used in a consecutive 60 month period, or for 5 years, the medical benefit entitlement can be closed. We began by looking at whether other jurisdictions had statutory provisions that made it easier for willing parties to settle their claims, including future medical benefits. We found that there is no clear and easy way to change our settlement provisions and we believe that requires further consideration by the Advisory Council.

But we did find in that process that 35 states have a statue of limitations on benefits. In other words if benefits are not used in a certain period of time, the claim is automatically closed. 22 states have statutes that close all or part of a claim if benefits are not used for

2 years. 8 states have provisions tied to 1 year of non use; 14 states have provisions tied to 2 years of non use. 14 of the 22 fully close the case – both medical and compensation benefits if no benefits are paid during the 1 or 2 year period. The other 8 states allow closure of either compensation or medical benefits if they are unused. 4 states allow full closure of both compensation and medical if benefits are unused for 3 years (South Dakota, Utah, Iowa and Pennsylvania). 2 states provide for closure of both if unused for 4 years (Wyoming and New Hampshire). As I mentioned Montana allows closre of medical benefits only if they are unused for 5 years. 5 states have provisions longer than 5 years but they all provide for full closure of the claim (both medical and compensation): 6 years in Hawaii, Oregon and Maine; 10 years in Rhode Island; and 12 years in Wisconsin.

Sixteen states do not have a statutory provision defining when a case or certain benefits in a case can be closed. We know that some of these states have administrative procedures for closing cases instead of statutory provisions. For instance, Colorado has a procedure to initiate closure of a case if benefits have not been used for 2 years. North Dakota has a process to close cases with no payments for 4 years. The department currently has staff contacting all of these states to determine if they have any administrative process for closing cases. If this bill proceeds, we will attempt to provide as accurate information as we can gather that shows how Montana compares on closure of cases.

This is important because insurers are setting reserves for the uncertainty of potential liability in open claims – known in the industry as IBNR (Incurred but Not Reported). Those reserves for IBNRs are added onto the known liabilities in establishing premium rates.

Section 2 of the bill deals with medical fees. Some of this language tracks identically language that is included in SB 108 sponsored by Sen. Cocchiarella which has already passed the Senate and is now pending before the House.

Paragraph 2(a) is in SB 108. The strikeouts at the bottom of page 4 and through line 14 on page 5 are also in SB 108. This combination of changes is to allow the department to set hospital reimbursement rates by rule. Our current hospital reimbursement rate does not have any rational logic to it. I think everyone agrees that representatives of the hospitals and payers need to sit down together with the department and agree upon a rational, fair methodology for hospital reimbursement and then establish that by rule.

Paragraph 2(b),(c), and (d) are the heart of what is new regarding medical fee schedules in this bill. 2(b) specifies that the rate for non hospital services, typical physician services to injured workers will be the predominant rate paid by group health insurers plus 10%. As you learned at the Conference, we currently are reimbursing primary care physicians at a rate very close to Medicare rates. We are reimbursing specialists – surgeons, anesthesiologists, and radiologists at rates that are considerably higher than Medicare and fairly significantly higher than group health payers. We believe that a

reimbursement rate that is 10% above dominant group health rate is a reasonable and fair rate given the increased paperwork required in workers' compensation cases.
This will provide an increase for primary care physicians who constitute the vast majority of physicians practicing in workers' compensation. These are the physicians that we hear are sometimes refusing to provide care to injured workers because their reimbursement rate is at Medicare levels and they can't stay in business if too much of their practice is at that payment level. This will provide greater incentive for primary care and remove an inappropriate incentive for excessive payment for invasive procedures.

This applies to physician services and not to hospital charges.

Paragraph 3(a),(b), and (c) is identical to language contained in SB 108. It allows the department to establish evidence-based utilization and treatment guidelines. This insures that injured workers receive the treatments that have been established by empirical studies and outcome based studies to most likely provide maximum healing and functional improvement. If treatments are not recommended in the guidelines, then they must be preapproved by the insurer with some justification that the treatment is indeed likely to provide improvement in the injured worker's health condition.

Mr. Vice-Chairman, members of the committee, it is the department's goal to find ways to reduce cost and correspondingly premiums to employers without cutting benefits or otherwise causing harm to injured workers. The department believes that HB 738 will contribute to the containment of cost without doing harm to injured workers. I anticipate that there will be some concerns raised by representatives of injured workers about some aspects of the bill. I would hope that all of the interested parties, representatives of injured workers, employers, insurers and medical providers can talk about issues, arrive at any needed compromises and be able to move forward in supporting those items that will reduce cost at no harm to injured workers.

Thank you and I will be available to answer any questions.

Labor-Management Advisory Council on Workers' Compensation

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